Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Garvagh House
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	03 April 2025
Centre ID:	OSV-0002348
Fieldwork ID:	MON-0046334

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Garvagh House is a residential service for five adults with intellectual and physical disabilities. The centre is operated by St Michael's House. The centre comprises a large detached house located in North County Dublin. There are four resident bedrooms, one staff sleepover room, a sensory room, quiet room, sitting room and kitchen/dining room, as well as a self-contained apartment attached to the main building. The centre is within walking distance of public transport and a range of local amenities which residents frequently use. There is a well-proportioned garden to the rear of the centre for residents to enjoy. The centre is managed by a person in charge with support from a deputy manager, and they report to a service manager. The staff team consists of social care and direct support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 3 April 2025	12:30hrs to 18:30hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre. The inspector used observations, conversations with staff, interactions with residents, and a review of documentation to form judgments on the effectiveness of the provider's arrangements to safeguard and protect residents from abuse, and how they ensured that residents' rights were being promoted and upheld in the centre.

Previous inspections have found ongoing and long standing incompatibility issues with residents living in the centre. This inspection found while the provider had made efforts to address the incompatibility issues, they had not been fully successful and the centre remained unsuitable to meet the collective residents' needs. The issues were also contributing to persistent safeguarding concerns and impacting on residents' quality of life.

However, there had been some improvements to the service since the previous inspection, such as initiatives to support residents to have more choice over how they spent their time and make decisions about their care, a reduction of some restrictive practices and improvements to the premises which the enhanced homeliness of the environment.

The centre comprises a large two-storey detached house in a busy Dublin suburb. The house is close to many amenities and services, including shops, bars, parks, and the beach. There is also a vehicle available for residents to access their wider community. The house comprises individual bedrooms, shared communal spaces including an open-plan kitchen and dining room, sitting rooms, a utility room, bathrooms, and a staff office. The smaller sitting room was being refurbished to be an additional sensory room. One resident resided in a small self-contained apartment connected to the house. The apartment contains a bedroom with an en-suite bathroom, and a small open-plan kitchen and living area. There are nice gardens at the rear of the house for residents to use if they wish to.

The inspector walked around the house with the deputy manager and a social care worker. The inspector observed enhancements to the premises since the previous inspection in May 2024. The kitchen had been refurbished, and nice photographs of residents were displayed in the hallway to make the house homelier. There were also new visual aids for residents to refer to, such as picture staff rotas and menus in the dining area. Some upkeep to the premises was required, and is discussed further in the quality and safety section of the report. The inspector also observed that some environmental restrictions had been lifted, including a half-locked door that divided the kitchen and dining room. These changes made the home more accessible to residents.

There were five residents living in the centre. The inspector met three of them. The residents appeared comfortable in their home, and with the staff supporting them.

One resident did not engage or communicate their views with the inspector. One resident briefly engaged with the inspector, but did not communicate their views. They pointed to their ears (staff told the inspector, that this indicated that the resident did not like noise). One resident briefly spoke with the inspector. They were enjoying a visit from their friend, and told the inspector that all was well in the centre.

One resident was at their day service during the inspection and in the evening went with staff to a nearby seaside town for their dinner. Another resident presented with symptoms of an infectious illness, and was isolating with staff support; therefore, the inspector did not have the opportunity to meet them.

The inspector read the provider's recent annual report, dated February 2025, which had consulted with residents and their representatives on their views of the centre. The review noted that residents appeared happy in the centre, and their representatives gave good feedback regarding the care they received. One family member said that they would prefer if their loved one lived closer to them. The inspector also read two compliments, from February 2025, from a resident's family member praising the staff team.

The inspector met and spoke with different members of staff during the inspection including two social care workers, the deputy manager, and the person in charge.

The deputy manager and person in charge had commenced working in the centre in September and October 2024. They told the inspector about their efforts to improve the residents' quality of life. For example, they had reviewed and reduced or removed some restrictive practices that impacted residents, they had decorated parts of the house to make it homelier, and they had introduced individual resident meetings for residents to have more opportunities to express their wishes. They told the inspector that the residents were in good health, and that the health of one resident in particular had hugely improved since the last inspection. Other improvements since the last inspection, included that one resident had moved to a more appropriate day service, and also was now allowing staff to support them with their personal care without the need for a restrictive practice intervention.

The local management team spoke about how some residents were negatively impacted by the behaviours of others. For example, some residents were assessed as needing a quiet and peaceful environment, but at times were upset and anxious about others residents making loud noises in the house. These loud noises were a frequent occurrence, and from 2pm to 6.20pm, the inspector counted nine incidents of loud vocalisations and one incident where a resident loudly banged property in the house. The management team were concerned that despite efforts from the provider and staff team, the incompatibility issues continued to negatively impact on residents' well-being and quality of life. They also said the physical environment did not suit some residents. Additionally, another resident's family had raised a complaint because their loved one was not attending a day service that was appropriate to their needs.

The management team spoke about the residents with warmth and compassion,

and it was clear that they were committed to promoting a human rights-based approach to residents' care. They were satisfied with the support they received from the service manager, and described the provider's multidisciplinary team as being very supportive and responsive to residents' needs.

The inspector spoke with two social care workers at different times during the inspection. The first social care worker had worked in the centre for several years and knew the residents' individual personalities well. They said the new management team were promoting a more person-centred service and residents were engaging in more social and leisure activities. For example, one resident was being supported to visit their family home on a regular basis after many years without visiting, and another resident was using a community service again for the first time since the COVID-19 pandemic.

The social care worker spoke about how the reduction and removal of some restrictions was having a positive effect; for example, some residents could now freely access the kitchen to make snacks and tea as they wished to. They also showed the inspector the new visual staff rota, menu, and communication signs displayed in the common areas. They said residents appeared to be happier, and that there was a reduction in the behaviours of concern displayed by some residents. However, they shared the aforementioned concerns about the residents' incompatibility. They also told the inspector that familiar and consistent staffing was paramount for some residents to feel secure.

The other social care worker also said that recently residents had more opportunities for social outings, and spoke about the different activities they enjoyed, including shopping, meeting friends and family, bowling, baking, swimming, massages, walking, and going to discos. However, there were occasions when residents' activities had been curtailed due to staffing issues. They also shared the aforementioned concerns about the incompatibility of residents and the suitability of the premises, and told the inspector about how residents were upset at times and anxious about other residents making noise, and required a lot of reassurances from staff. Staff also tried to manage the environment as best they could by pulling down blinds at certain times of the day to reduce the likelihood of some residents seeing each other and becoming upset. They had completed safeguarding training, and could describe the procedure for responding to and reporting concerns. They were satisfied with the support and supervision they received, and praised the management team on their commitment to promoting a more person-centred service in the centre.

The inspector found that the provider, the management team, and staff working in the centre were endeavouring to provide a quality and safe service for residents. However, the incompatibility of residents in the centre was adversely impacting on their safety and quality of life, and had not been effectively resolved by the provider.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided in the centre. This inspection focused on the provider's arrangements for safeguarding adults from abuse and ensuring that their rights were promoted and protected.

The inspector found while efforts were being made to ensure that the centre was well resourced and operated in line with the residents' needs, these efforts were limited in effectiveness. Staff arrangements were not adequate to meet residents' needs, and the provider had not mitigated the long standing resident incompatibility issues that continued to impinge on their safety and quality of life.

There was a clearly defined management structure with lines of authority and responsibility. The structure included the person in charge, a deputy manager, a service manager and a director of service. The management team demonstrated a good understanding of the residents' needs and concerns about the current service provided to them.

There were good oversight and monitoring systems in place. Annual reviews (which consulted with residents and their representatives) and six-monthly unannounced visit reports, and a range of audits on areas had been carried out to identify areas for improvement. While, the inspector observed some improvements since the previous inspection in 2024, the main issue (residents' incompatibility) had not been resolved by the provider.

The staffing arrangements at the time of the inspection were not fully in line with the residents' needs or effective in ensuring consistency of care. There were five permanent whole time equivalent vacancies. The inspector reviewed the recent staff rotas which showed a high-use of agency and relief staff to cover the vacancies. This was impinging on the quality of the service provided in the centre. The provider had recruited for three of the vacant posts; however, those staff had not yet started working in the centre.

The inspector did not review the staff files (as detailed in Schedule 2). However, the provider submitted confirmation to the inspector that all staff had up-to-date vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

The inspector reviewed the staff training log, and found that some staff had not completed all required training, as determined by the provider, or were due refresher training. This posed a risk to the quality and safety of care they provided to residents.

There were effective arrangements for staff to raise concerns. In addition to the

support and supervision arrangements, staff also attended team meetings.

Regulation 15: Staffing

The registered provider had not ensured that the staffing arrangements, at the time of the inspection, were appropriate to the needs of the residents and that they received continuity of care and support.

The inspector read, and was told by staff, that residents required consistent and familiar staff. However, there were five permanent whole-time equivalent vacancies which were covered by staff overtime, relief and agency staff. Three of the vacant posts had been recruited for; however, those staff were not due to start working in the centre until May 2025.

The inspector reviewed the planned and actual rotas for February, March and April 2025. The rotas showed a high use of relief and agency staff:

- The February rota showed that relief and agency staff worked 59 shifts.
- The March rota showed that relief and agency staff worked 88 shifts.
- The April rota showed that relief and agency staff were to work 87 shifts.

This was not in line with the residents' needs and preferences, and did not ensure their consistency of care. Staff told the inspector that when the centre was short staffed or using high levels of agency staff, residents opportunities for social outings could be limited or curtailed. For example, on 27 March 2024, one resident's planned trip to a nearby seaside town did not take place.

The inspector also found that the actual staff rotas required better maintenance as they did not clearly record the full names of all staff working in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, administration of medication, manual handling, emergency first aid, infection prevention and control, positive behaviour support, and fire safety.

The staff training log viewed by the inspector showed that some had not completed all required training or were overdue refresher training. For example:

- Positive behaviour support: Two staff required full training, and three staff

required refresher training.
- Supporting residents with challenging behaviour: One staff required full training.
- Supporting residents with modified diets: Two staff required full training.
- Safe administration of medication: Two staff required refresher training.

The inspector also found that the provider's medication management policy required more information on staff training. It stated that staff must complete administration training, but did not outline if staff could administer medication if their refresher training was overdue. On the day of the inspection, two staff were overdue refresher training, and the inspector was given conflicting information on whether they could still administer medication or not.

The management team were enhancing the training programme for staff to drive quality improvements in the centre. Staff had completed bespoke training on 'understanding trauma' to enhance their knowledge on the topic, and were scheduled to completed report writing training.

The person in charge provided informal support and formal supervision to permanent staff. Formal supervision was due to be carried out four times per year. However, staff had not received formal supervision in 2024 quarter 4. This was attributable to a change in management (since January 2022, there had been six different persons in charge). Staff spoken with told the inspector that they were happy with the support and supervision they received.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had endeavoured to ensure that the centre was adequately resourced, governed, and monitored to ensure the delivery of safe and consistent care and support to residents. However, they had failed to resolve the incompatibility issues, and the staffing arrangements had not been in line with residents' assessed needs.

The provider had formed a service improvement team (which included members of the senior and local management team) to review the quality and safety of the service, particularly in relation to incompatibility issues. The provider was also engaging with their funder for additional resources to mitigate some of the issues, and had reviewed their internal resources to identify possible alternative centres for residents to move to. However, their efforts were so far limited in effectiveness and there was clear no time frame for when the issues would be mitigated.

There was a clearly defined and effective management structure with lines of authority. The person in charge was full-time, and based in the centre. They had commenced in their role in October 2024, and were supported by a deputy manager

who had commenced their role in September 2024. The management team were seen to be driving improvements to the service provided to residents. For example, they were reviewing restrictive practices to assess if they could be reduced or removed, improved documentation standards, and had decorated the house to make it homelier. The person in charge reported to a senior manager (who in turn reported to a director of service). The inspector found that the management team were well-informed on the residents' individual personalities, and on the service to be provided to them.

There were good oversight and monitoring systems. Annual reviews consulted with residents, and the provider's quality team carried out six-monthly unannounced visit reports to identify areas for improvement. Audits were also carried out in areas including health and safety, personal plans, and medication.

Judgment: Substantially compliant

Quality and safety

This section of report focuses on regulations related to the quality and safety of the care and support provided to residents in the centre and how it affects residents' safety and wellbeing. Overall, the inspector found that residents' assessed needs were not being fully met in the centre, and this was having an adverse impact on their wellbeing and safety. For example, there were recurring safeguarding issues due to the incompatibility of residents.

The person in charge and provider had ensured that residents' needs were assessed. The assessments of residents' needs were reviewed on an ongoing basis and were used to inform written care plans. The inspector reviewed a sample of three residents' assessments and care plans, including the plans on health, communication, behaviour, intimate care, and safety. The plans were generally up-to-date and readily available to guide staff practice. Some communication plans had not been subject to review by a relevant multidisciplinary team member as requested due to resource constraints. However, the director of service told the inspector that the provider was liaising with their funder to source additional resources to increase the capacity of the multidisciplinary team to resume communication assessments.

The management team had implemented arrangements for residents to be consulted with and express their views. They attended house meetings where they planned their main activities, and discussed any concerns they may have and topics such as the complaints procedure and restrictive practices. The inspector found that the use of restrictive practices had reduced, and in some cases, ceased, and this was having a positive impact on residents. Some additional improvements were required to ensure that all restrictions were being applied in line with evidence-based best practice and the provider's policy. For example, not all restrictions have

been approved for use by the provider's oversight group, and some of the associated care plans required more detail.

The provider had determined that residents were not compatible to live together due to their varied and complex needs. The incompatibility of residents was adversely impacting on the quality and safety of the service provided to them. The inspector found that safeguarding incidents had been reported, and safeguarding plans were in place. However, the safeguarding arrangements were not fully effective, and this was seen through recurring incidents and ongoing concerns expressed by staff, the management team, and residents.

The premises comprises a large two-storey detached house. The house comprises individual resident bedrooms, a sitting room, open-plan kitchen and dining room, utility facilities, a sensory room, a staff office, and rear garden. There was also an attached self-contained apartment for one resident. The premises was observed to be clean, and parts of it had been renovated and redecorated since the previous inspection in 2023. However, some additional upkeep was needed.

Furthermore, the environment was not fully suitable for all residents. For example, some residents required a quiet and peaceful home; however, there was frequent loud noises and incidents which affected residents' wellbeing. The inspector also found that while efforts to ensure that residents' rights were upheld; the incompatibility issues impacted on their movement around their home, and not all residents could freely access their own money.

Regulation 10: Communication

Residents used a variety of modes to communicate. Some communicated verbally, while others used multi-modal communication means such as word, pictures and manual signs.

Written plans had been prepared to inform staff on each residents' individual communication means and how to support them to express themselves. In the main living space, there was also a large notice board with pictures of the main manual signs used by one resident for staff to easily refer to. There was also a visual menu, staff rota, and activity planner for residents to use.

There was Internet in the centre for residents to use, and residents used smart devices and virtual assistive technology, and had subscriptions to stream different media forms including music, videos and music.

Judgment: Compliant

Regulation 17: Premises

The premises comprised a large two-storey detached house with a front driveway and rear gardens. Within the premises, there are individual residents' bedrooms, an open-plan kitchen and dining room, sitting rooms, a utility room, a sensory room, bathrooms, a staff room, and a small-apartment that one resident lived in.

Residents' bedrooms were personalised to their tastes and provided sufficient space for their belongings. Since the previous inspection, the kitchen had been refurbished. New photos of the residents were also on display in the hallway to make the space more homely, and a notice board in the kitchen-dining room displayed relevant information for residents such as on the staff rota and menu. The person in charge was also converting a spare sitting room into another sensory room; the room had already been repainted and there was a new television and sofa.

The house was bright and appeared to be clean. However, some minor upkeep was required. The paintwork in common areas including the main hallway and kitchen-dining room was scuffed and stained in places, the fence outside one resident's bedroom required repair, and the veneer on a bathroom storage unit was damaged and posed an infection hazard as it could not be cleaned effectively.

The premises was also not suitable for all residents. Some residents required a quiet and peaceful environment, but were exposed to loud noises from other residents on a regular basis. Additionally, the apartment was limited in space which posed a risk to staff safety. This issue had been assessed by the management team as being a high risk.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy that outlined how risks were identified, assessed, controlled and monitored. The inspector reviewed a sample of the risk assessments relevant to the centre and individual residents.

The assessments related to a wide range of risks including residents' incompatibility, accidental injury, aggression and violence, and the premises' hazards. The risk assessments were up to date and clearly outlined the measures to be in place to reduce and mitigate the risks.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had not ensured that the centre was suitable or that appropriate arrangements were in place to meet the assessed needs of each resident. This judgment was also found during previous inspections of the centre.

The provider had assessed residents' needs and determined that they were not all compatible to live together due to their complex individual needs, and that the environment was not suitable. The incompatibility issues were having an adverse impact on some residents' lived experience. Concerns about residents' incompatibility were highlighted in multiple sources, including residents' care plans, risk assessments, safeguarding reports and plans, compatibility assessments, multidisciplinary team records, and audits such as the annual review and unannounced visit reports.

The provider had made efforts to mitigate this long standing concern. For example, one residents' environment had been reconfigured and a service improvement team had formed to review and improve the matter. However, the issues remained unresolved.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had implemented systems to ensure that residents received support to manage their behaviours of concern. The inspector reviewed three residents' behaviour support plans. The plans were up to date, had been prepared with input from the provider's multidisciplinary team, and were available to guide staff practice. The management team told the inspector that the provider's psychology department were very responsive and provided support to the residents and staff team as required. Staff spoken with were knowledgeable on the strategies outlined in the plans, and the arrangements for recording behaviours of concern.

Staff were required to have relevant behaviour support training to help their understanding of positive behaviour support. However, as detailed under regulation 16, not all staff had completed this training; and this posed a risk to the quality of the care and support provided to residents.

There was a significant amount of restrictive practices implemented in the centre. The restrictions included night checks of some residents, locked doors and windows, restricted use of smart devices, a lap strap for one resident while using their wheelchair, a seat belt cover for one resident while travelling in the centre's vehicle, and garments to prevent one resident from engaging in self-injurious behaviour.

The new local management team were committed to reducing the use of restrictive practices in the centre. They were reviewing all of the restrictions, and had removed some such as the locked half-door in the kitchen, locked wardrobes in a resident's bedroom; and had significantly reduced the use of the aforementioned garments. These efforts were contributing to a more open and less restrictive environment; for

example, residents could now freely access the kitchen to prepare snacks and make tea as they wished.

The inspector reviewed the documentation related to a sample of the restrictions to determine if the restrictions were managed in line with the provider's restrictive practice policy. The inspector found that improvements were required. For example:

- The protocol for one restriction did not take into account the resident's views.
- There was an absence of clear and detailed guidance for staff on carrying out night checks (this posed a risk to residents' privacy).
- Not all restrictions had been approved for use by the provider's oversight group.

The director of service told the inspector that the provider was forming a new rights committee who would have oversight of the restrictions and give approval for restrictions where appropriate.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents from abuse, which were underpinned by a written policy. However, these systems were not fully effective, and the ongoing incompatibility issues were impacting on residents' wellbeing and quality of life. At the time of the inspection, five notifications of allegations of peer-to-peer abuse had been submitted to the Office of the Chief Inspector of Social Services in 2025, and in 2024, 33 notifications of that type had been submitted.

Staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Safeguarding was a standard agenda item at staff meetings, and the person in charge had also arranged for the provider's social worker department to attend a recent staff meeting to guide them on how to report any safeguarding concerns. Staff spoken with told were able to describe the procedures. The inspector reviewed a sample of the safeguarding incidents reported in 2024 and 2025, and found that had been appropriately reported and notified to the relevant parties.

Safeguarding plans had also been prepared, as required, which outlined the measures to protect residents from abuse. However, the plans were not mitigating the concerns. Most safeguarding concerns in the centre stemmed from the incompatibility of residents. Staff and the management team told the inspector about how residents were being affected. For example, at times they were upset and sought reassurance from staff. The inspector also read similar concerns in documentation, including safeguarding reports and plans, behaviour records, and residents' meeting minutes. For example, a resident said during a February 2025

meeting that they do not like when other residents are loud, a safeguarding plan from October 2024 noted that there is no resolution to the issues and that residents need a peaceful environment, and a safeguarding report from March 2025 noted that residents continue to experience distress that is impacting their quality of life.

Judgment: Not compliant

Regulation 9: Residents' rights

There were arrangements to promote the rights of residents in the centre; however, the ongoing incompatibility issues impinged on some residents having free access to all parts of their homes at all times, and not all residents had access to their finances.

As described throughout the report, some residents were distressed when other residents made loud noises, and this impacted on how freely they could use their home. For example, during loud vocalisations, some residents were redirected to or chose to retreat into other rooms to minimise the impact on them. Staff also tried to manage the environment by pulling down blinds at certain times of the day to reduce the likelihood of some residents seeing each other and becoming upset.

The person in charge had made efforts to enable residents to have better access to their money. For example, residents' monies were now securely stored in their bedroom instead of the staff office. However, two residents could not access their finances, as they were managed by other persons. Staff told the inspector that this restriction limited their opportunities for spontaneous purchases. The provider's social work team were liaising with the relevant parties to support residents to have more control over their money.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Garvagh House OSV-0002348

Inspection ID: MON-0046334

Date of inspection: 03/04/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A Recruitment Campaign was advertised on the 22/04/2025 • One permanent WTE started on the 01/05/2025 • One permanent WTE is starting on the 01/06/2025 • One WTE Relief Staff is Starting on the 01/06/2025 • Relief Staff available for Part Time Permanent Post on the 01/09/2025. recruitment Process to commence.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • 2 staff have been scheduled for Full Positive Behaviour Support training on the 9th and 30th of July 2025 • 3 staff have been scheduled for Positive Behaviour Support refresher on the 11th of September 2025 • 1 staff is scheduled for TIPS training on the 30th of June and the 14th of July. • All Staff have completed training on Modified diets on the 07/05/2025 • All Staff have completed Safe Administration of Medication on the 04/04/2025 • All 4 Formal Supervisions with all staff are scheduled for 2025- First Quarter completed 31st of March. Remaining Dates for Supervision meetings 2025 sent by email on the 24/04/2025 to all Staff.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Service Improvement team will meet on the 13/05/2025 to address ongoing Compatibility issues
• Ongoing Consultation for one resident to move to another designated centre commenced on the 08/04/2025
• Residential Profiles were discussed at the Residential Approvals Committee meeting on the 09/05/2025
• Person in Charge reviewed one Restriction on the 09/05/2025 to include the Resident's views
• Business Case for funding will be resubmitted to the HSE on the 19/05/2025 in relation to increasing residential occupancy within another Designated centre
which if successful will increase capacity in Residential services. Also, another avenue for funding is being explored and an additional business case will be submitted 22nd May and if successful it will be aimed at increasing residential capacity.
• Pending approval, a tendering process and build completion, we would expect this to be completed and occupied by Feb 28th 2026.
• The members of the Executive Management team will schedule a meeting by the 31st of May 2025 to discuss priority cases across residential services.
• The provider is also exploring a property that could be reconfigured to increase residential capacity. A business case will be submitted to the HSE to access the required funds, to meet the requirements of fit out as a designated centre. Following this an application for registration with HIQA will be submitted.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• Technical Services reviewed upgrade work required for Garvagh on the 06/05/2025. This will be placed on the technical Services workplan for 2026
• Contractors measured Fence on the 06/05/2025. Scheduled to be complete by the 3rd Quarter 2025.
• Bathroom Storage Ordered on the 09/05/2025
• Ongoing Consultation for One Resident who lives in the Apartment to Move to another Centre commenced on the 08/04/2025

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Service Improvement team will meet on the 13/05/2025
• Ongoing Consultation for One Resident to Move to another Centre commenced on the 08/04/2025
• Residential Profiles were discussed at the Residential Approvals Committee on the 09/05/2025
• Business Case for funding will be resubmitted to the HSE on the 19/05/2025 in relation

to increasing residential occupancy within another Designated centre
which if successful will increase capacity in Residential services. Also, another avenue for funding is being explored and an additional business case will be submitted 22nd May and if successful it will be aimed at increasing residential capacity.
• Pending approval, a tendering process and build completion, we would expect this to be completed and occupied by Feb 28th 2026.
• The members of the Executive Management team will schedule a meeting by the 31st of May 2025 to discuss priority cases across residential services.
• The provider is also exploring a property that could be reconfigured to increase residential capacity. A business case will be submitted to the HSE to access the required funds to meet the requirements of fit out as a designated centre. Following this an application for registration with HIQA will be submitted.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The Person In charge Reviewed one Restriction on the 09/05/2025 to the Include Resident Views.
• Support Plan for One Resident's night checks reviewed on the 17/04/2025 to Include clear and Detailed Guidance for Staff
• Referral sent to Positive Approaches Monitoring Committee on 31/03/25 for harness and angel clip for one resident and approved on 15/04/25
• 1 staff booked in for TIPS training on the 30th of June and the 14th of July

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Service Improvement team will meet on the 13/05/2025
• Ongoing Consultation for One Resident to Move to another Centre commenced on the 08/04/2025
• The Designated Officer continues to review, submit and monitor Safeguarding Plans to reduce the risk of abuse
• A Compatibility Assessment/Review is ongoing this will remain open until the Panel have resolved the incompatibility concerns within the Centre.
• A meeting with the HSE Local Safeguarding Team will take place on the 27th May 2025
• Residential Profiles were discussed at the Residential Approvals Committee on the 9th May 2025 highlighting the need to address the compatibility issue within the centre.
• Business Case for funding will be resubmitted to the HSE on the 19/05/2025 in relation to increasing residential occupancy within another Designated centre
which if successful will increase capacity in Residential services. Also, another avenue for funding is being explored and an additional business case will be submitted 22nd May and if successful it will be aimed at increasing residential capacity.
• Pending approval, a tendering process and build completion, we would expect this to be completed and occupied by Feb 28th 2026.
• The members of the Executive Management team will schedule a meeting by the 31st of May 2025 to discuss priority cases across residential services.

• The provider is also exploring a property that could be reconfigured to increase residential capacity. A business case will be submitted to the HSE to access the required funds to meet the requirements of fit out as a designated centre. Following this an application for registration with HIQA will be submitted.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• The SMH Safeguarding Committee is in the process of addressing issues ensuring all residents have access to their own monies.
• The Resident Monies policy is currently in the final review stage, will reflect the principles of the Assisted Decision-Making Act, and will articulate a rights based approach to resident's finances. This policy will be in place by June 30th 2025.

• All Residents will and preference has been sought in relation to finances.

• The provider will issue the final letter and make relevant notifications for example, HSE Local Safeguarding Team, HIQA and Garda Notifications by June 2025.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/10/2025
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/10/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	31/10/2025

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	31/03/2026

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2026
Regulation 07(2)	The person in charge shall ensure that staff receive training in	Substantially Compliant	Yellow	20/09/2025

	the management of behaviour that is challenging including de-escalation and intervention techniques.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	31/07/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	09/05/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	15/04/2025

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/07/2025
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	31/07/2025